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FALL 1951

FOR THE PHYSICIAN IN GENERAL PRACTICE

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THE COVER

The "Cover Girl" for this issue lives to eat. Stuffing herself with food is her major enjoyment in life. She is typical of a large segment of the neurotic obese who, denied the emotional satisfaction of normal living, compensate by taking in quantities of food their bodies do not need. A more complete discussion of the problem may be found on page 78.

The painting on the cover was executed by Mr. George E. Shackelford.

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THE Psychiatric BULLETIN

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anxiety

ANXIETY was meant to be a lifesaver. Whether a vague apprehension or a concentrated feeling focused on a specific object, it is a universal signal to the human organism that "all is not well." In days of atomic debacles, job insecurity, and rising divorce rates, a certain amount of anxiety in people is the expected, normal reaction. Indeed, as Rollo May says: " . . . living without fear in the twentieth century shows weakness of mind, or more accurately, insensitivity, atrophy of mind."

However, some persons overreact to the normal threats of living. These are the pathologically anxious—those who because of their anxiety have become ill. Pressure headaches, muscular pains, nausea, and diarrhea abound in these patients. Their mental symptoms can include a lowered intellectual efficiency, slower, more inaccurate thinking, and a lessened ability to think up new ideas or to adjust to new situations quickly. Also such patients are especially confused by social relationships, because their emotions are involved.

Etiology

The foundations of chronic anxiety are thought by many psychiatrists to lie in the early emotional experiences of the patient—especially those experiences involving the patient's early relationships with his parents.

Threat is one of the first experiences a human being feels. Indeed some psychiatrists believe the birth experience itself is felt as a violent threat to the newborn baby. If so, a subjective feeling of anxiety is probably one of the earliest emotions experienced by the human organism. After birth many additional frustrations (threats) beset the baby. Feeding and sleeping frustrations, sensations of loneliness (when the mother leaves the baby alone too long or neglects it in other ways), sudden sensations of falling and countless other threats, real or imagined initiate the child into the anxieties of living.

Toilet training and other later activities involved in the child's socialization impose increasing restrictions. The child learns to in-

hibit natural impulsive behavior to avoid punishment. Aggressive, sexual and other forbidden actions are held in check. The child even learns to inhibit his thinking of such forbidden things. However, the child cannot always refrain from *thinking* about doing these things, and such repressed thoughts of forbidden things battling for conscious recognition in his mind can arouse additional anxieties in the child.

Each child (and grown person later) has to work out his own ways of handling these inevitable anxieties. Methods of controlling anxiety are as numerous and varied as human personality itself. How each person handles anxiety will determine the main features of his behavior. In the case of the chronically anxious patient the symptoms of the patient's illness represent the personality's way of handling anxiety, a pattern of reaction the patient has probably been using for many years. The life history of such patients is usually replete with illness and physical incapacities whose accompanying symptoms were unduly excessive and prolonged.

The actual onset of anxiety symptoms in a patient may be gradual or sudden. Where symptoms appear suddenly, a precipitating stress such as physical illness, emotional or physical shock usually is the trigger mechanism which generates excessive anxiety and sets the machinery in motion. The patient complains of symptoms long after one would reasonably expect the effects of a precipitating illness or shock experience to disappear. This residue of symptoms probably stems mainly from an emotional source and as such requires psychotherapy.

Psychotherapy is Indicated

The chronically anxious patient needs help in finding ways of handling his anxieties which are less handicapping to him physically, socially, and in his business life.

Barbiturate or other symptomatic therapy temporarily relieves these patients, but the only *cure* for chronic anxiety is psychotherapy. Symptomatic measures are recommended for acute states of panic or to relieve unbearable physiological conditions, but it is suggested that the patient be clearly informed that these measures are for temporary relief and that only an investigation into the patient's life history will reveal the causes of his condition and lead to cure. If the patient accepts this (the physician must first believe this himself, of course) psychotherapy has already had a good start. The patient will perhaps by then have felt the subtler effects of a comfortable emotional relationship with a person he respects and in whose presence he can freely unmask the hidden, less attractive sides of his nature.

The Patient's Story

A physician once said: "If a doctor will listen to what a patient has to say, the patient will almost tell him the diagnosis." The patient's story is helpful in the diagnosis and treatment of any illness. It is essential in the diagnosis and treatment of an anxiety state.

It is helpful in treating an anxious patient to remember that probably the original cause of his anxiety was a feeling of helplessness, a feeling of being deserted in time of need. Guilt feelings about forbidden sexual and aggressive impulses later probably contributed to these original feelings of anxiety. The physician's willingness to accept these things in the patient on the patient's own terms is a direct and immediate attack on these fundamental psychological disturbances. An understanding attitude in the physician begins to restore the patient's confidence in people. This is the basic objective of therapy. Concomitantly the patient discovers that sexual and aggressive impulses are accepted by the physician as normal and natural, and this helps to reduce the intensity of their threat. The anxious patient needs to learn that people are not as hostile as he has unconsciously interpreted them to be, that aggressive and sexual drives are common to everyone and that a socially acceptable outlet for these emotions can be found. He also needs to learn that he is not as helpless as he unconsciously thinks he is. This is a reeducation problem—reeducation in the very real sense of experiencing these very things he needs to learn. In the special environment of the therapeutic relationship the patient finds that the physician

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Transference

POSITIVE & NEGATIVE

Many physicians regard transference as an experience occurring only in a special therapeutic situation, not realizing that in most interpersonal relationships transference and countertransference elements are at work.

During treatment certain emotions and attitudes in the patient emerge and are directed toward, or transferred to, the physician. This is known as transference. These responses have their origin in the emotional give-and-take that the patient experienced early with the significant people in his life. The child soon senses the characteristic feelings his parents have toward him and reacts to these feelings in various ways until he automatically hits upon an emotional response, or a combination of responses which help him deal with the parents. Later, he uses these same attitudes toward anyone he unconsciously casts in the role of one of these significant people, however differently this later person feels and acts toward the patient.

It is, therefore, with these apparently illogical and unwarranted emotional reactions that the physician deals in transference.

As Fenichel expresses it, "The patient misunderstands the present in terms of the past; he strives, without recognizing the nature of his action, to relive the past and to live it more satisfactorily than he did in childhood. He transfers past attitudes to the present." This is a useful mechanism for the patient in that it helps him escape the memory of painful past experiences while allowing him some emotional discharge.

The patient's feelings toward the physician may be of a positive nature, such as liking him and attempting to please him because of the help given in a difficult situation. On the other hand the transference may be a negative one, the patient hating the doctor for making him undergo painful and unpleasant memories. He may be totally illogical in loving or hating the therapist. The doctor may have the experience of once-cooperative patients becoming surly and suspicious, just as he may have the difficult situation of a patient becoming overly fond of, and dependent on him.

While the analysis of the transference situation is the work of the specialist, and indeed is one of the main tools of psychoanalysis, the management of the transference situation is something that most physicians have to cope with in any form of therapy of the patient, even though the treatment may be primarily medical or surgical. He should watch for the troublesome manifestations—the negative ones of suspicion, hostility, refusal to carry out the instructions—or the positive one of too frequent office calls, or phone calls or perhaps even sexually-tinged overtures made by the patient. His response to the hostile, aggressive attitude should be as patient, tolerant and non-punitive as possible, while with the overly fond and dependent one he must be kind and dignified, neither too aloof nor too accessible. If the physician is to be genuinely helpful to the patient, his response to either aspect of his patient's relations with him must be on a friendly, accepting, non-critical basis, and he may cautiously point out the emotional attitudes which he sees displayed, and help the patient understand their illogical nature and, perhaps, the links with some important person in his past.

The term countertransference is applied to the way the doctor feels about the patient. Because of his wide experience with so many different types of people, the physician finds it much easier to maintain complete objectivity than do his patients in their professional relationship. If, however, he falls prey to unprovoked feelings of hostility, or overgratification in relation to a patient, he should make a mental note that, after all, he is human, too, and then set about to curb any attitudes he has which he may consider unjustified. The well balanced physician will have no difficulty in keeping to a minimum any emotions which can interfere with his effectiveness in dealing with his patients. Indeed, one learns a great deal about oneself in becoming aware of the emotions and their sources as they are called forth in dealing with patients —a learning experience that further strengthens and implements the physician's ability to deal with people.

Suggested Reading

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Satty

EVERYBODY knows the type. His friends call him "Fatty" or "Fatso," "Two-Ton" or "Man-Mountain." Occasionally some who consider themselves more imaginative will dub him "Lard-Pot" or "Elephant Boy." He, of course, is not expected to resent this good-natured kidding. Legends steeped in error have grown up about his placidity, his joviality, and the downright especial joy he gets out of living. As "Mr. Five-by-Five," he has even been immortalized in song. Actually, many fat persons are frustrated, uncomfortable and generally miserable. Indeed, surplus flesh may be a by-product of the underlying discontent which drives them to the solace of food. This usually occurs in the absence of any appreciable endocrine imbalance. Such a person gets fat simply because he overeats. The question facing his physician is not "why is this patient fat," but "why does he overeat?" Behind the awesome spectacle of a truly heroic appetite may frequently be found a history of emotional starvation. The process of eating may be the body's attempt to compensate deep-seated yearnings which are primarily psychological.

Inquiry into the background of the voracious eater often reveals a history of deprivation. Most likely it will be emotional deprivation, but occasionally it may be economic as well. During childhood many such persons were denied the simple gratifications of their basic psychological needs. Average requirements for love and affection may have gone unsatisfied. Or, in an environment of economic stringency, the place of food may have loomed gigantic in the family structure. With such a background food comes to represent security. Years later, its very consumption still brings comfort and reassurance to hungering emotions. Without understanding that there may be an emotional basis for his appetite, such an individual devours huge meals, taking multiple helpings of the richest and most fattening foods. Between meals he may seize further opportunity to nibble on candies and cakes. It is of very little use to explain to him the desirability of balancing the energy intake and output. He will probably concede that exercise is not feasible, since it would take, roughly, thirty-six miles of walking to work off one pound of fat. But it will be difficult to convince him that, given sufficient water, he could fast for weeks without seriously endangering his health.

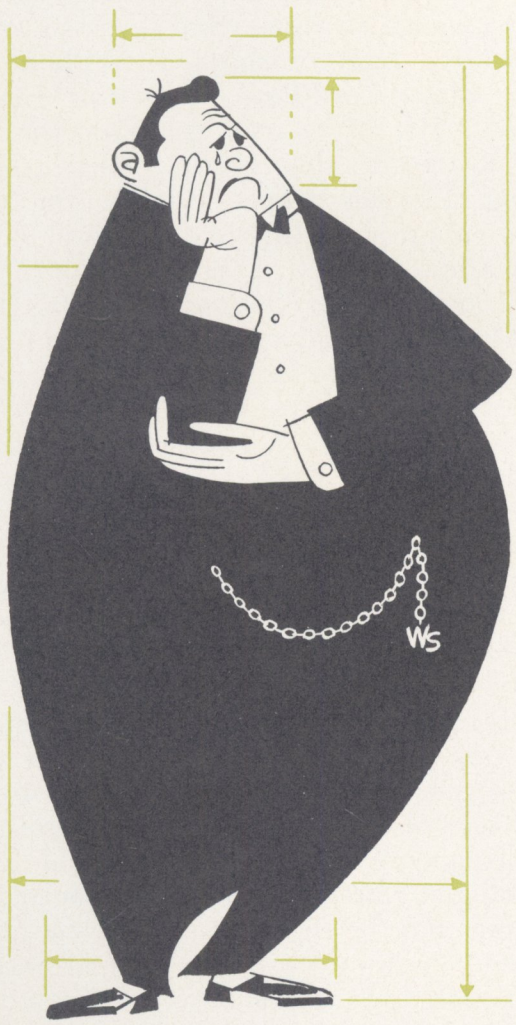
Since his appetite so far exceeds his metabolic requirements, it is quite a task for the prodigious eater to adhere to a carefully planned submaintenance diet. He may say he would like to lose weight. Usually, however, he fondly hopes this may be accomplished by the *ingestion* of some form of medication which will have a magical reversing effect on his glands. He will not so readily welcome the prospect of relinquishing all his favorite foods. Failure, therefore, often is encountered by treating such a patient with an adequate low-calorie diet, even though it may be supplemented by appetite-reducing drugs. Among the foremost of these is amphetamine sulphate, sometimes given in conjunction with vitamin B-1. Consumed indiscriminately, amphetamine sulphate is not without ill-effects, since it can be habit-forming and constipating and may cause giddiness, irritability and

insomnia, and, in larger doses, even a delirium. When this occurs, the patient will probably return to the unique comfort he finds in food. The emotional glutton differs from the average eater in that his appetite only increases with worry, since he eats to relieve anxiety in the first place. In a life of habitual frustration and boredom, eating can indeed become the individual's major gratification.

With patients in this category, superficial psychotherapy has yielded some interesting results. One team of investigators selected 93 patients, all obese and all apparently affected with some psychological disturbance. They divided them into three groups; 38 were treated with psychotherapy alone. Their motive in overeating was interpreted to them in the light of emotional, rather than physical craving. Their histories were studied for maladjustments on the social, sexual and economic levels. A simple explanation was given them of the connection which can exist between psychological disturbance and excessive appetite. It was suggested that once they recognized that eating was an artificial and inconclusive way of meeting emotional problems, it would be much easier for them to exercise natural control over their appetites. The second group consisted of 35 patients who were placed on a strict diet of 800 calories per day. There was no supplemental medication and no attempt was made to explain a possible psychological basis for their immoderate eating. The third group consisted of 20 patients who were given drug therapy only, with no specific diet and no psychotherapy. After one year has passed, the results of the survey were as follows:

Of those treated with psychotherapy alone, 70 percent had lost considerable weight and maintained the weight loss for as long as one year. Of those placed on a diet, only 26 percent had succeeded in retaining any weight loss for the same length of time. Of those treated with drugs alone, none lost any significant poundage whatsoever. The researchers who conducted the survey felt that their findings indicated the importance of an emotional factor in many cases of obesity which should not be disregarded if success is to be achieved in a reducing program.

Another investigator, Dr. Harry B. Richardson of Cornell, went even deeper into the same problem. He selected one typical case, a middle-aged woman who had been overweight since childhood. Her history revealed that in early years she had been the "ugly duckling" of her family. Their circumstances were poor, and although her basic physical needs were supplied, there was never enough left over for little things to give her pleasure. Anything extra was always showered on her younger



and more attractive sister, for whom both parents showed decided preference. Thus rejected, the patient turned to the pleasures of eating. In the environment of repeated frustration she ate more and more. As she got fatter and fatter, she was provided with a physical alibi for any personality defects which might handicap her socially. She withdrew from the company of others, taking refuge behind her cushion of fat.

It was explained to the patient that a thwarted and unhappy childhood can be sufficient basis for eating one's way to obesity. In order to tie this in with her own case she was asked to report any dreams she might recall. This she did, and her dreams yielded some surprising and valuable information on associations existing in her mind.

In one, she dreamed she was at a banquet. The table was lavishly set, but there was no place for her. In another dream she saw two carts of wine which rumbled to a stop in the middle of a village street The wine was given out to a gathering crowd, but none was left for her. It was pointed out that these dreams might symbolize the deprivation she experienced in childhood. In another dream she was looking at some cans of milk on a pantry shelf. As she hungrily reached for one, the cans all turned into people. A similar substitution amused and edified her in another dream. This time she dreamed she saw two men. Since they were not very large anyway, she reached for some salt and began sprinkling it on them so she could cook them. While recounting this dream she laughed and commented that it must signify it was time to transfer her interest from food to men. The therapist said that, indeed, she was on the right track if she could recognize the relationship between her greed for food and her need for affection. One other dream was all that was needed to convince her that, for her, the joy of eating had replaced the most important things in a woman's life. In this dream she opened her icebox, only to find a warm, naked baby curled up asleep on a plate among the refrigerated foods. She concluded then that food had been her substitute for the home, love and children which had been denied her. With this understanding the patient was enabled to turn her major interest away from food and to her fellow man. She acquired a suitor. And, incidentally, she lost fifty-three pounds.

Certainly in this case the therapist had usually fruitful material to draw from. Not every patient has such a telltale source of dream lore as this one. Not all cases are so simple to interpret or so satisfactorily treated. However, this case does

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WRINKLING, BLINKING, & NOD

Gerald started doing this his first term in school, Doctor. Why does he always jerk so?"

Before you sits what would be a splendid looking child . . . if only he could keep his features still for a minute. Instead, his little face is being yanked repeatedly into a pattern of wrinkling up his brow, blinking tight his eyes, and jerking down his head. This is but one of the limitless combinations seen in the multiple, uncontrolled and irreversible motor responses known as tics. Other forms include mouth twitching, shoulder shrugging, and spasmodic motions of arms or legs. In a small percentage of cases there are also involuntary throat noises, ranging from unintelligible gurglings to explosive shouts of obscenity.

There is a certain rigidity of pattern that characterizes the tic syndrome. The motions are sudden and brief, like an electric shock. They restrict themselves to certain muscle

groups and tire these out with identical repetition. Once started, the process is virtually impossible to divert from its established course.

That there is a psychosomatic basis for many of these manifestations is indisputed. But it is necessary first to determine whether the motor apparatus has been upset by an organic cause. In the event of injury to the brain or spinal cord, for example, a certain lack of motor coordination may result, giving the familiar picture of spasticity. Also, in the various types of chorea, or St. Vitus Dance, there are repetitious muscular contractions which are beyond control of the patient. However, the motor manifestations seen in chorea are less coordinated and involve larger groups of muscles than do tics. Psychomotor epilepsy also should be differentiated from the habit spasms seen in tics. Any unexplained neuromotor irregularity warrants clinical search for a possible physical source. Electro-encephalograms, x-rays, tests of the spinal fluid and other examinations may be employed. Even negative laboratory results do not entirely rule out the possibility of obscure physical impairment. Certainly, one is not justified on the basis of negative physical findings alone, in diagnosing a disorder as psychogenic. Frequently, however, an investigation of the patient's history will reveal certain trends which form a basis for severe personality disturbances.

Like Gerald, here.

"*He is our only child—our baby*," his mother goes on. "*He used to have an older sister, but she died when Gerald was a baby.*" The mother pats the seven-year-old boy tenderly on his twisted, restive cheek. A few more remarks reveal that for seven years the entire household has revolved around Gerald.

"*He was so precious. The only one, after sister's passing . . . no chance to have any more, my O. B. said.*"

Exhibit Number One: The child has held too much importance in the family circle.

The mother recalls one of his first attempts to crawl.

"*The little darling headed for the stairs. I grabbed him up, of course. It frightened me so.*" After that, it develops, they kept him safely in the play pen, long after he was well able to walk.

Exhibit Number Two: Restriction of motility was coupled with a display of strong emotion. As the account goes on, more and more evidence falls into line. Gerald's slightest attempts at freedom had been curbed and penalized.

This background is reduplicated a thousandfold in the homes of children who later develop tics. Like all young creatures, the human baby has a strong need for violent motor activity. He also needs adequate outlets for aggressive and affectionate impulses. He needs space to run in, though he may trip and fall . . . things to pound on, though he may smash his thumb . . . and plenty of love, but not the stifling kind. He must be encouraged in self-reliance if he is to grow in self-control.

Parental anxiety is readily transmitted to a child. An over-solicitous parent will often impose perfectionist standards. This rigid discipline only heightens emotional tension in the child. He may try hard to curb his impulses in the manner expected of him, but lack the strength to cope with his desires. It is not surprising then, that one day his emotional tension breaks through in the form of uncontrollable motor release. He may appear grotesque in the throes of his tic. Nevertheless, it serves him as a safety valve.

Tests on tic patients have shown them to possess deep, strong and sometimes violent feelings. Their histories reveal that repeatedly these children were denied adequate outward expression of their emotions during early life. Frequently, abnormal restraint of motility only resulted in increased motor urge. Also,

overprotection had made these children emotionally dependent and weak in self-control. The tic children studied never had been given a chance to develop the kind of self-reliance necessary to meet the demands of normal living. With repeated curbing of natural impulses, a formidable reservoir of pent-up resentments, energies and tensions can accumulate. When these tensions reach a certain point, depending on the individual's tolerance, this dammed-up energy may force itself out into the open. In the case of the tic patient, the particular outlet chosen is involuntary muscular contraction. Where a conducive state of mental stress pre-exists, the initial tic manifestation can be set in motion by many different kinds of stimuli.

For example, one case has been reported of a ten-year-old girl who competed with other children in a breath-holding contest, following which she developed an inspiratory tic. A second little girl showed involuntary pushing movements of the arm after she had been overpowered and raped. Another provocation was seen in the boy who, nagged constantly by his father about his scholastic standing, shook his head during the entire school year, only to have his difficulty vanish during summer vacation. That tics can be induced by unnecessary sternness is shown by the experience of one particular class in school. The principal discovered that a number of children in the same class had developed tics. Investigation revealed that these students had an unusually stern and demanding teacher who bullied the entire class. Those children already predisposed by weakened emotional defenses developed tics.

But how about Gerald's case? Well, the first time that Gerald experienced that tic, it may have had some special, inner meaning. In the presence of intense excitement, he may have frowned to express protest, and squeezed his eyes shut to blot out some unwelcome sight. At the time, this may have relieved the accompanying explosive emotion. But today, it is automatic and frustrating, and serves no apparent purpose.

You watch the child's hectic facial maneuvers. What is the best way, you are thinking, for that emotional tension to be safely removed? You are not concerned with the tics now. You want to help the boy. If his personality difficulties could be resolved, the tic might very likely take care of itself.

"By the way, Jerry," you begin. "What is your favorite sport?" You notice how his eyes brighten when you say Jerry. He is about to answer when his mother speaks.

"I heard about some exercises for him to do before the mirror. They helped a neighbor's child who had polio. But with Gerald, they only made things worse."

Of course. The tic is disfiguring and foreign to his will. Watching it can only increase his feeling of helplessness and defeat. Tics are not tricks, employed deliberately for sympathy or gain. As manifestations of emotional stress, they are often accompanied by other maladjustments, such as enuresis, digestive disorders, and exaggerated fears. Mirror exercises may be splendid for strengthening and retraining atrophic muscles, and at one time they were advocated in the treatment of tics.

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DERMATOLOGY has been called the best specialty because the patient never dies—and never gets well. Although this gentle flippancy is a deliberate exaggeration, it is true that any physician occasionally sees a troublesome case of chronic dermatitis which reminds him of the adage. A patient whose skin itches, oozes, or otherwise shows stubborn irritation, will probably consult a dermatologist or other practicing physician. In some cases, when no physical irritation is involved, the patient might do just as well to see a psychiatrist. Perhaps some of them would, if they realized how frequently their skin disorders appeared in conjunction with some emotional disturbance. Many people however—especially those having tangible ailments—will see no reason to classify themselves as "psychiatric patients". In such cases the family physician can sometimes do much to alleviate the difficulties, both inside and outside, by maintaining a sympathetic and understanding attitude toward the case.

Symptoms similar to contact dermatitis

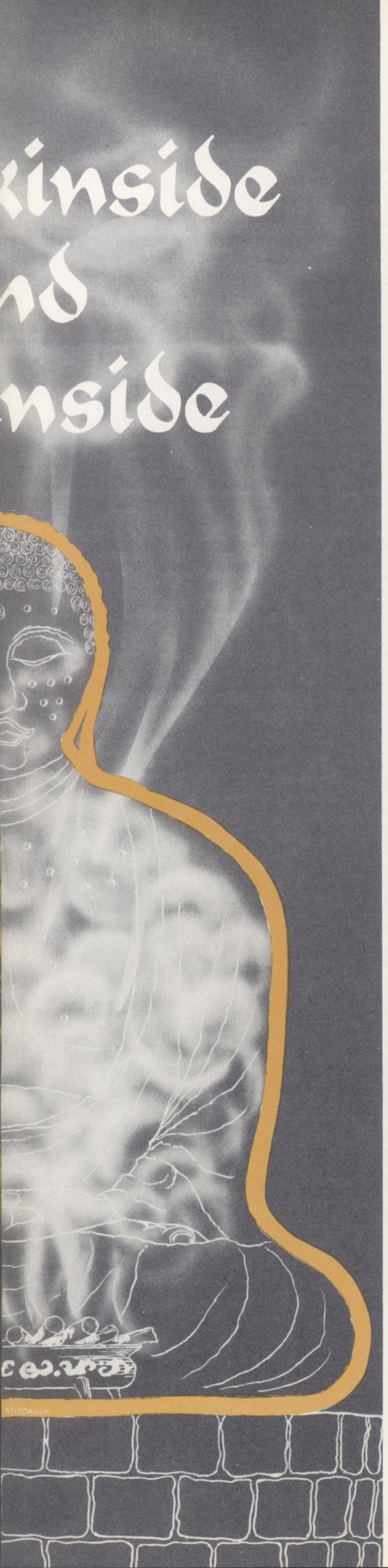
The dermatological "problem case" presents symptoms similar to those of various forms of contact dermatitis. The condition may be totally resistant to all forms of therapy commonly prescribed in skin afflictions. Scores of allergy tests may prove inconclusive. No evidence of fungus or animal parasite may be found. There may be no indication of deficiency disease or subcutaneous vasomotor deviation. Yet the patient itches. Or he breaks out in a rash. His skin presents annoying red patches or eruptions, hives or scaliness, compelling him to seek relief by various measures. When no organic basis for the inflammation can be found, the physician is justified in taking a look at the patient's emotional adjustment in search of some internal conflict which may be finding expression on the surface of the skin. Frequently, in cases of this nature, questioning will reveal that the skin reaction comes on the patient "in spells", and that these occasions have coincided with, or followed, specific instances of emotional upheaval.

There are other patients occasionally seen by physicians who actually have no serious emotional problems, yet remain in a state of habitual nervousness. Their patterns of thinking are constantly torn with petty anxieties. These are the perfectionists. The same precarious emotional stability which makes them perfectionists keeps them perpetually upset. No wonder they fall victim to psychogenic illness, including dermatitis and many others.

There are still others whose cutaneous ailments become useful devices for influencing others. An example of this is the jealous father who scratched furiously, diverting his wife's attention, whenever the baby cried. This desire to monopolize an important individual is seen in reverse in the case of the four-year-old girl whose convenient itch considerably disrupted her household. The extent of tyranny exerted by this little patient is shown by the fact that for a year and a half the mother had been going to bed with the child instead of with her husband. Every night the little girl's itching skin was babied, rubbed, greased and soothed till one of the principals fell asleep. When, during the interview, the therapist suggested this was hardly a feasible bedtime arrangement for man and wife, the child was seized with a sudden attack of itching, which drew the mother's attention immediately from the discussion back to her.

Psychosomatic theory well-established

The idea that an emotional element is pertinent in certain skin difficulties is not a new one. This phenomenon was mentioned by Noah Worcester in his book "Diseases of the Skin," published in 1845. Still, there are authorities today who minimize any relationship between the emotions and the skin. While acknowledging that mental and dermal disturbances co-exist, they deny that one results from the other. In an effort to find specific evidence of precipitating factors, Wittkower and Edgell made a study of 90 patients in British hospitals, all suffering from eczema and other forms of dermatitis. They report



that "a correlation between emotional disturbances and eczematous manifestations could be established in 77 of the 90 patients studied . . . Altogether 174 episodes could be isolated in which onset, relapses or aggravations of eczema were clearly related to emotionally disturbing situations."

In a painstaking survey of 53 cases of infantile atopic dermatitis, Dr. Donald H. Williams of Vancouver presents further evidence of the interrelation between cutaneous changes and emotional dissatisfaction. He begins by pointing out the complexity of etiological factors involved in this disease. Prominent among them is maternal rejection, which all of the cases appeared to have in common. The reaction of the children to this rejection took two forms of expression: an emotional outburst of hostility to the mother, and a physical eruption of lesions on the skin. For comparative therapy, the children were divided into two groups. Twenty children made up the "control" group. These were treated with local applications, planned diets, and the best available protection against potential allergens. No attempt whatever was made to alter the relationship between mother and child. In the other group of 33 children, therapy was directed specifically at the maternal rejection factor, though bland topical applications were not withdrawn. In each case, the mother was interviewed alone for a long discussion of the emotional needs of children and the detrimental effects which can result when these emotional needs are not fulfilled. The material was presented in such a way that it would not constitute an indictment of the mother. Rather, it was acknowledged that, tired and overwrought as she probably was, she might be in many respects the victim of a difficult-to-handle, strong-willed child. She was told that *because of this very situation*, she must try to reinforce her understanding and cultivate more patience with her child. Several ways were suggested for achieving this. She was advised to:

Stay well rested and in good health herself. Avoid emotional "scenes" within the home. Prevent situations which lead to a "clash of wills" with the child.

Relax discipline when possible, and follow necessary punishment with prompt and tender forgiveness.

Express affection for the child openly and often every day.

In every way possible, bestow "extra dividends" of maternal love upon her child.

Following an observation period of 24 months, it was found that 30 of the 33 children in this group were decidedly improved. Indeed, half of these were entirely freed of symptoms. These benefits were rapidly effected. In the control group, only two out of the 20 showed a corresponding clearing of the skin, though several had gradual improvement to a limited degree.

Threats, vanities and conflicts precipitate attacks

In adults, dermatitis has been known to arise following threats to physical safety, blows to self esteem, and exacerbations of sexual conflict. Dermatitis associated with guilt feelings is seen in the patient who, during periods of marital infidelity, broke out on the *wedding ring finger only*. Guilt feelings may also be involved where vulvar, penile, scrotal or anal pruritis coincides with frustrations or repressed perversions in the sexual zone. More serious was the guilt felt by the woman who developed pruritis following her son's paralysis. This mother had prevented her son from being hospitalized during the first three critical days of poliomyelitis. When it became apparent that the child would be permanently incapacitated, she felt responsible for the seriousness of his condition. For two and half years following this her skin was covered with red, itching and scaly patches. She had consulted many physicians and tried numerous treatments without success when it was decided to try psychotherapy in addition to local therapy. An effort was made to lessen the itching by hypnotic suggestion. Under hypnosis, the patient suddenly cried out, "This is the itching of my conscience which bothers me. I blame myself for his illness and my skin has shown my guilt." It was suggested to her that one reason she was always "tearing herself to pieces" was to punish herself and expiate a subconscious feeling of

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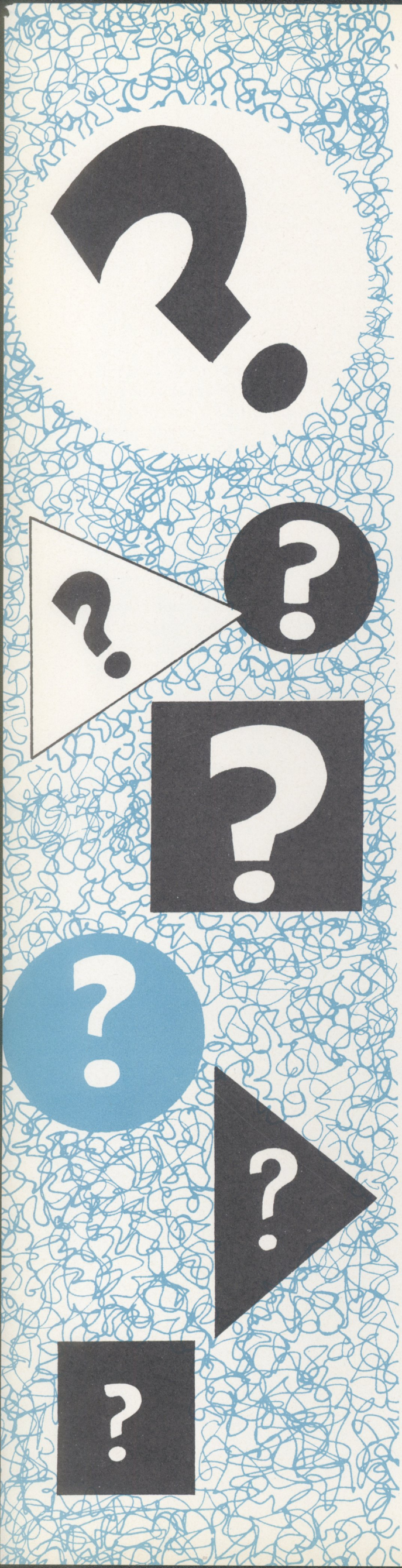


QUESTION: What percentage of psychiatric patients are able to resume their place in society?

ANSWER: Statistics taken at Boston Psychiatric Hospital over a one-year period reveal that 81 percent of the patients committed during that year were able to return to their homes after treatment. Most satisfactory results were obtained with the manic-depressive and involutional types of mental illness. Of the schizophrenics, 79 percent were able to be discharged to their homes. In terms of the length of hospitalization, 75 percent were discharged within 90 days and 90 percent within six months. However, it must be noted that not all remain well; there is some incidence of recurrence. It is reasonable to expect that with continued improvement in therapeutic methods and with more and better trained custodial personnel, the discharge rates for patients in psychiatric hospitals will steadily increase.

Bockoven, J. S. et al., Treatment Results in the Major Psychoses, New Eng. J. Med. 244:357 (Mar. 8) 1951.

QUESTION: What is the meaning and importance of "insight" in psychotherapy?

ANSWER: Insight is the patient's understanding of an emotional basis for his disturbance. When insight is achieved by the patient, the way is then open for the reconstruction of his personality in a manner more adaptable to his environment. The patient cannot be given insight by being told facts; he must gain it for himself. The patient must participate in his own readaptation. The important thing is that he must recognize the emotional basis for his troubles, and he must try to overcome his undesirable patterns of behavior. He cannot do this until he has achieved insight into his underlying difficulty.

Reference: Freeman, M. J., Reinforcement Therapy: A Re-evaluation of the Concept of "Insight" in Psychotherapy, Am. J. Psychotherapy, 5:32 (Jan.) 1951.

QUESTION: How can the physician obtain a psychiatric history without offense to the patient?

ANSWER: Often the physician can tell he is dealing with an emotional illness by the way the patient recounts his symptoms. This is especially true when the patient is allowed to present his case in his own words instead of by answering direct questions. Even a clear cut psychotic, if he keeps his mouth shut, can deceive a physician who is giving him a physical examination. When the patient unhurriedly tells his own story, little resentments will often come out naturally. Most mistakes are the results of hurried interrogation. When the patient makes a statement that is not entirely clear, the physician can request him to clarify the statement. Often the second time the patient tries to explain a situation he may reveal entirely new facts. The physician must avoid the temptation to suggest symptoms because the patient may adopt them just to please him. Sometimes a patient may hesitate to bring up disturbing new facts. It will not hurt if the physician inquires routinely whether the patient is getting along all right, whether he is happy, and if not, what seems to be bothering him most. It is often difficult to obtain facts regarding insanity in the family. If asked point blank whether any of his relatives are insane, the patient may become defensive and deny it hotly, even though he knows his maternal uncle is in a mental hospital. However, the same patient, if asked gently whether anyone in the family has ever been nervous enough to have to consult a doctor, may come forth with the facts. When the question is put, "have any of your relatives ever been driven into regrettable behavior by the cruelty of someone else?", for instance, the patient may produce willingly a great deal of valuable information.

Alvarez, W. C., The Neuroses, Philadelphia, W. B. Saunders Co. 1951, p. 56.

QUESTION: What effects have been achieved with histamine therapy in patients with psychiatric disorders?

ANSWER: In the treatment of over 500 psychiatric patients, histamine was used experimentally for some conditions in place of electroconvulsive therapy. It seemed to achieve promising results without producing the convulsions. Also, pre-treatment with histamine appeared to enhance the effectiveness of electroconvulsive therapy and sub-coma insulin shock treatment. Some schizophrenics were benefited to the extent that their bizarre activity abated and commitment to mental hospitals was avoided.

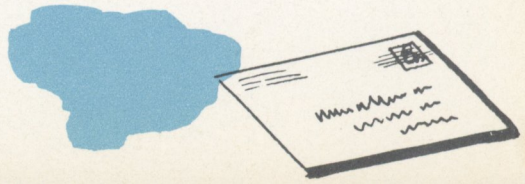
Sackler, R. R. et al., An Appraisal of the Current Status of Histamine Biochemotherapy in Psychiatry and the Theoretical Significance of its Effects, J. Clin. and Exper. Psychopathology, 12:5 (Mar.) 1951.

QUESTION: Can psychoanalysis do anything to help the homosexual patient?

ANSWER: If the patient is sufficiently troubled about his homosexuality to consult an analyst or a physician about it, he may be helped to overcome or to adjust to his aberration. Where an endocrine insufficiency is recognized early enough, hormones may be administered with beneficial results. In the majority of cases, however, no physical basis can be found for homosexuality. Freud has observed that homosexuality is "assuredly no advantage", but it is "no vice, no degradation, it cannot be classified as an illness: we consider it to be a variation of the sexual function produced by a certain arrest of sexual development." When Freud was asked if he could help the homosexual, he replied, "you mean, I suppose, if I can abolish homosexuality and make normal heterosexuality take its place. The answer is, in a general way, we cannot promise to achieve it. In a certain number of cases we succeed in developing the blighted germs of heterosexual tendencies which are present in every homosexual . . . If he is unhappy, neurotic, torn by conflicts, inhibited in his social life, analysis may bring him harmony, peace of mind, full efficiency, whether he remains a homosexual or gets changed." Because of the unjust public tendency to regard homosexuality as a crime, the homosexual feels classed as a culprit and called upon to defy public opinion in defense of his behavior. When viewed in the light of a medical problem of arrested development, rather than a daring accomplishment, he may find that his homosexuality has less attraction for him. He might then be impelled to try to repress it, and proceed to normal sexuality.

Freud, S., A letter, Am. J. Psychiat. 107:10 (Apr.) 1951.

THE editors welcome any questions physicians would like to have discussed regarding the clinical handling of psychiatric problems in general practice. Every effort will be made to find answers to such questions and to reflect in these answers the best current psychiatric thinking.



THE SKINSIDE AND THE INSIDE

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guilt. In a case which involves deep-seated feelings such as this one, caution must be taken to see that the patient becomes conscious of his underlying difficulty very gradually. A mind made aware of painful feelings too suddenly may find them too much to accept and withdraw from reality for a while.

Most cases show no serious mental illness

Most patients, however, who show the characteristics of a nervous dermatitis seem to carry their emotional problems close to the surface of their minds. In such instances the physician can frequently elicit the state of affairs with a few sympathetic questions. Should he learn that "things at home leave much to be desired," or "they may have to cut some salaries down at the plant," the way is open for him to help the patient recognize the possible connection between his emotional and cutaneous maladjustments. No counselor has a better opportunity to invoke the confidence of a patient than does the family physician. The patient expects his "family doc" to sit down and visit with him. Thus, the first step in the therapeutic procedure—rapport—is already established. Then, the physician can gradually discover whether an emotional maladjustment exists, and if so, how severe it is and how accessible to therapy. More than any other professional person, the physician has an opportunity for giving special encouragement to people who need it. He can often achieve rewarding success in dealing with emotional problems.

An Omaha physician reports a gratifying experience in this regard. He had a patient with long-standing dermatitis on his leg. No physical treatment seemed to help him. Finally, the physician had a talk with the patient—a businessman. He explained the complex ramifications which may be found with such a condition. He prescribed mild ointments and asked the patient to take it easy for a while and let the world go by. A month later he received a letter from the man. It said, "your medicine did me absolutely no good because I did not use it, but your lecture was excellent. I have had almost no itching for the past three weeks and my skin is almost well."

There may be many other patients, now victims of stubborn skin disorders, who would benefit from the same type of therapy. Perhaps with the many-faceted help of their physicians, they may find relief, both from their emotional explosions on the inside, and from their physical eruptions on the skinside.

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Joseph, E. D., et al: A Psychological Study of Neurodermatitis, J. Mt. Sinai Hosp. 15:360 (March-April) 1949.

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FATTY

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suggest some of the emotional forces that motivate the obese person. Every patient has a life history. A look into it may be illuminating. The insight thus gained may throw light on underlying causes for any number of physical ills. Obesity can be one of these.

A contemporary wit may have thought he was merely turning a fast phrase when he said that everything he wanted was illegal, immoral or fattening. But the thought he expressed strikes close to the problem of the emotional overeater. For this gourmand may emerge from his dilemma when he realizes that his desire to be accepted by others is not illegal, and his need for physical love is not immoral, but the rich food he craves is certainly fattening, and offers, after all, no substitute for friendship and affection.

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SECOND CHILDHOOD

The PATIENT is waiting in the outer office. His granddaughter waits by his side, while his daughter has "a few words in private" with the physician.

"Doctor, it seems that Pops is getting worse and worse," she observes. "He's over 70 now, you know. He's so careless these days. Why, it's getting dangerous to have him around the house." She tells of the time he turned on the gas burner in the kitchen and forgot to light it. Luckily, that time all the windows were open.

"And forgetful!" she continues. "Hides things where not even he can find them. Can you imagine putting the keys to the safety deposit box inside some boots he hasn't worn for 30 years?"

The picture of senility unfolds. Pops has been getting more unreasonable than ever. He seems to take delight in being peevish and grumpy, and unpleasant to have around. He is obstinate and opinionated and finds fault with everything the daughters do. He putters aimlessly around the house, particularly at night. Sometimes he can't find his way back to bed.

Socially, he is impossible. He is so neglectful of his clothing he has to be watched whenever company comes. But even watching won't keep him from insulting them if he feels like it. Besides, he gets the most fantastic ideas. Twenty-five years a widower, he announced just last week that he was going to marry the young widow who lived across the street. He might have managed it too, if he had been a rich old man.

The patient comes in, leaning heavily on his granddaughter's arm. Anyone can see his old body is tired and worn. The history reveals that several months before he had a slight stroke. After that, a noticeable tremor appeared in his hands, so that he no longer writes legibly. He drags his feet when he walks. Sometimes he has dizzy spells and in one of them he fell, barely missing the stairs. His voice is weak and tremulous. There are times when he starts to talk, but seems to change his mind.

When questioned, the patient appears uncooperative and somewhat confused. He refuses to answer directly but preoccupies himself with reminiscences, even recalling a touchdown he made over 50 years ago. Still he cannot, or will not, remember what he ate for breakfast that very day.

Protesting, Pops undergoes a physical. Tests reveal that his organs are performing their functions with lowered efficiency. The years have taken their toll. The physical things are bad enough, but it is the change in his personality that worries the family.

The arbitrary behavior of the old man is closely associated with bodily changes. A patient with advanced senile deterioration with arteriosclerosis will frequently show this type of mental impairment. When degeneration has progressed this far, is there anything the physician can do to retard the processes of attrition? Sometimes there is.

First, measures may be taken to improve the patient's general health. The patient can be treated directly

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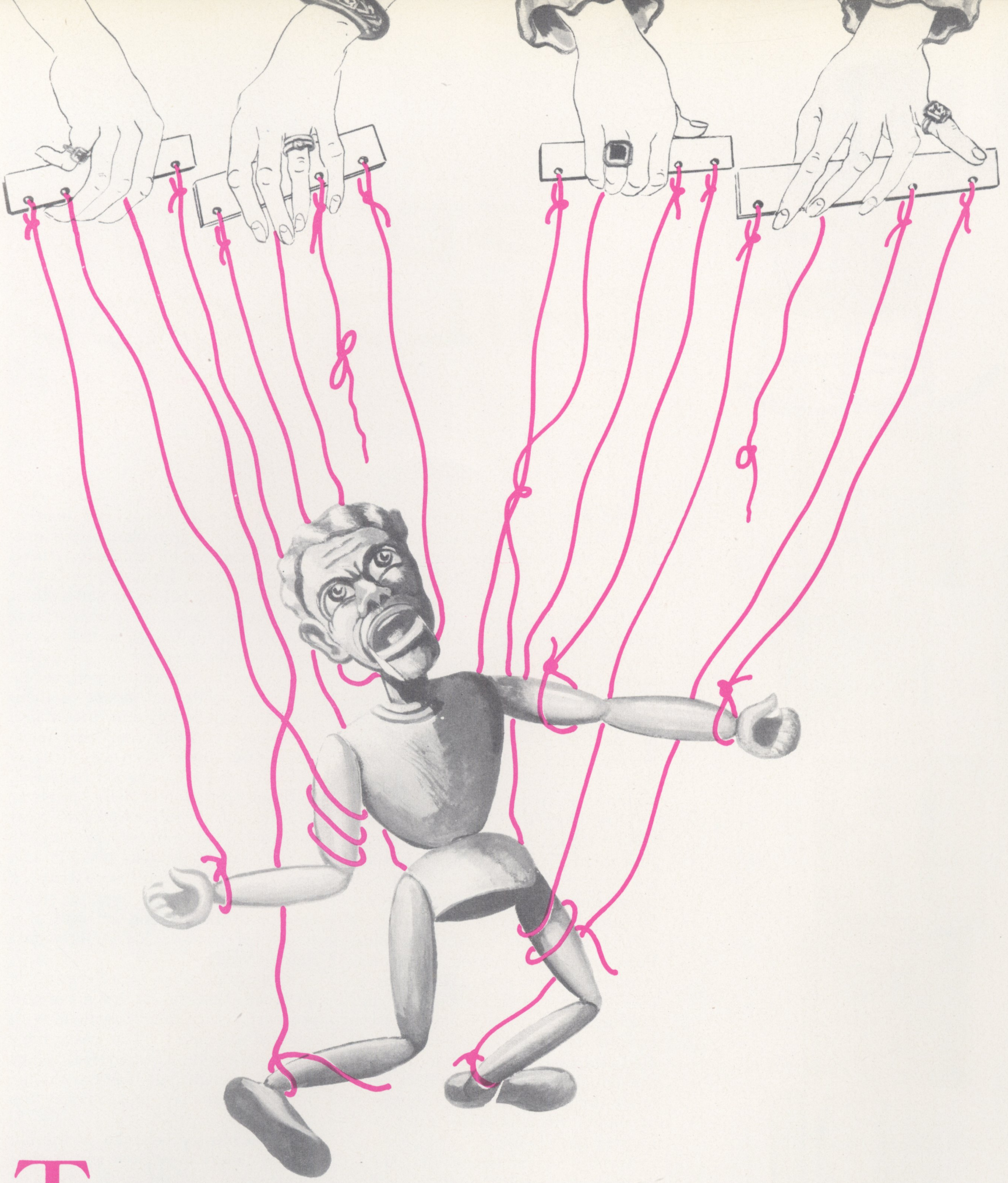

THE PATIENT, a thirty-one year old sales-engineer, was admitted to a general hospital April 12, 1951, complaining of extreme agitation, anxiety and pains in the chest and stomach. He first consulted his family physician in November 1950 for burning epigastric pain, vertigo and nausea. X-rays and other studies showed only a mild pyloro-spasm. The physician was struck by the great tension of the patient. A bland diet, belladonna, and anti-acids gave some relief. Note was taken of the patient's observation that his symptoms were initiated or made worse when he started home in the evening or when the entire family dined out. His symptoms grew worse and he began to think he had heart trouble because of tachycardia and pains around the heart. His physician reassured him, and advised him to take up interests outside the home and office. Despite these measures he got worse, and was referred to an internist in March, but nothing new was discovered. Finally,

anxiety amounting almost to panic dominated the picture, forcing hospitalization, and a psychiatrist was called in.

PAST FAMILY SITUATION: The patient was the only child of a wholesale furniture salesman, a tolerant, easy-going man, who was dominated by the patient's mother, a very sweet, determined, rigid woman. The income was always good but she spent money to excess. In many respects the patient was indulged greatly. He was never given an allowance, but his parents got him anything he desired. Although he had a few minor chores to do around the house, he was not allowed to have a paper route or earn money in the ways other boys usually do. Though his mother often promised punishments, she usually failed to deliver them. When he started to college, he was not permitted to attend one away from home. Shortly after he started to school his father died suddenly of a heart attack. A week later the patient was operated

on for appendicitis. While in the hospital he had a panic attack similar to the present one. During his college years his mother kept him closely attached to her. When he was around twenty he had an affair with a girl who was much in love with him, and their sexual relations were very satisfactory to both. Her family put pressure on her to make a debut rather than marry him, and she submitted to their wishes. Shortly thereafter and just prior to graduation, he fell in love with another girl. His mother objected to her on grounds of religious differences as well as the possibility that his interest was on the "rebound." Despite this he joined her church and married her within six months. From the beginning the marriage was a disappointment to him. The wife was cold and unaffectionate and felt repulsed by sexual relations which she considered sinful and dirty. Their incompatibility reached into other areas too; she was domineering and self-sufficient as the mother had been, and their only common interest was the two children who were born two years apart. About two years prior to hospitalization, the mother moved into their home, because the patient never carried out his vague plans for her living elsewhere. The two women now took over and ran all aspect of the family life. Over the patient's feeble protests, they spent the remainder of the mother's estate buying things he felt they could not afford. Working harder at his job, he spent more and more time away from home and engaged in a number of extra-marital affairs. One of these partners, a married woman, found herself pregnant just about a month before the patient saw his physician the first time. Although he was reasonably sure the child was not his, he could not entirely convince himself, felt more and more guilty and upset and finally sought his physician in November.

PSYCHOMETRIC EXAMINATION: This showed the patient to be of superior intellectual capacity.

TREATMENT: The patient was admitted to the hospital and the general practitioner, internist, and psychiatrist worked with him as a team. Sedatives in large amounts were given throughout the day and night. He soon brought out his resentment of his mother's and wife's domination and the resulting feelings of helplessness. His anxiety and guilt feelings increased as these factors were elicited and he became mildly suicidal. His psychiatrist had to leave town for two weeks, during which time he was cared for by a woman psychiatrist. His symptoms suffered such a marked exacerbation that he appeared to be on the brink of a major psychotic episode. He included the woman psychiatrist in the resentment and hostility that he felt for his wife and mother, and began to have fantasies of hurting women in a physical way. After discussing these feelings with him, the woman offered to withdraw and secure him a male psychiatrist. He considered this for several days, and decided to retain her, feeling that failure to deal with her in a temporary relationship would mean that he dispaired of ever dealing successfully with women. Following this decision, his symptoms began to abate, for the first time since he had been admitted to the hospital. This marked a turning point in his therapy because it represented the first time in his dealing with women that he was actually called on to make a significant decision. With the return of his former psychiatrist he kept on improving and left the hospital after a total stay of six weeks.

DISPOSITION AND FOLLOW-UP: He continued to see the psychiatrist in regular office visits and worked out alternate plans for handling his relationships with the wife and mother.

PROGNOSIS: If the women involved were able to alter the character of their relations with the patient, he would get along well. At this time they refused to see the necessity of this or even of the mother's living outside the home. This makes the prognosis guarded for it demands that *all* changes be made by the patient, a condition that he probably will not be able or want to meet. This means that he will probably require supportive treatment at intervals in the future. If things become too difficult, he might possibly become psychotic.

DISCUSSION: Much remains to be worked out, but enough has been solved for the patient to resume employment. The effectiveness of even a trivial aspect of management can be influenced by the psychopathology. In this case, the sex of the

therapist aggravated the hostility resulting from the patient's submissiveness to women. When he was given a choice of therapists, this hostility abated. The longer such basic conflicts remain unresolved, the more widespread and serious are the consequences. The patient's marriage, his overwork, his affairs and his physical symptoms were his own partial solutions, one being tried as soon as the preceding one failed. Each added to his burden of anxiety, making each new solution less likely to succeed. Only after these emotions had broken through the defenses could the underlying problem—his need for emancipation from female domination—be seen and solved through his assumption of a mature masculine role.

WRINKLING, BLINKING & NOD

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Now authorities feel that therapeutic measures directed to the tics themselves are undesirable, since they disregard the underlying difficulty.

The tic patient needs help in the attainment of self-confidence and the recognition of his own inherent value. He needs a reasonable amount of freedom to express his feelings, and he needs the reassurance that many of his stifled impulses are normal and justified. Sometimes this guidance can be given by the family physician, in a series of understanding interviews with the child and his parents. The superfluous motor urge can often be diverted into purposeful channels. Motor energy can be directed into competitive athletics. Aggressive impulses can be released through hammering, whittling or modeling. The desire for self-expression can be met through dramatics, arts or handicrafts.

Since a study of the etiology of tics indicates so forcibly the importance of environmental background, parents of tic patients might well be closely questioned in an effort to find and correct contributory factors. Most difficult will be reversing the parental habit of overprotective thinking which leads to pathological dependency in the child. It may take much time and several consultations, but many parents ultimately can be helped to attain a greater degree of objectivity. In this way the mother of such a child may come to realize the importance of widening the

horizons and lifting the restrictions on her child. She may eventually understand how much the child would benefit from more varied and less exacting personal relationships. When this degree of progress is attained, she should welcome the idea that lifting his restrictions and permitting the child to develop in his own way may be all that is needed to eliminate the tic. She may even be encouraged to plan new ways of broadening his opportunities for social exchange and satisfying self-expression.

You find that you have been talking to Gerald's mother for half an hour. You have just begun your "parent therapy". To your relief, she appears interested and cooperative. She says she would like to talk with you about Gerald again. You make the appointment. That mother is a loving parent . . . misguided, perhaps, but more in ignorance than in stubbornness. Above all, she wants to help her child. They rise to go. As they reach the door, you shake hands with the boy.

"By the way, Jerry," you ask. "What is your favorite sport?" He grins between grimaces as he replies.

"Baseball."

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SECOND CHILDHOOD

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for any infectious conditions, and, in some cases, they can be eliminated. A regimen of fluids, vitamins and high protein foods may prove beneficial. Mild barbiturate sedation may help restore normal sleeping habits.

With such supportive treatment, senile patients often improve sufficiently to be amenable to suggestion. Talking with the patient may then reveal specific experiences which aggravate his feelings of insecurity. Some of these feelings may have a basis in fact. In many families, elderly persons are relegated to an insignificant role in the household. Without realizing it, close relatives may cause their elders undue anxiety by brushing off as trivial their views and suggestions. Part of the reason the elderly person forgets recent events is defensive. He likes to live in the past because things were more pleasant then than they are now. In the old days, he was important. Now, he feels superfluous.

The physician can often help such a patient's relatives to gain a more tolerant attitude to his idiosyncracies. While explaining to them the physiology of aging, he can tell them something of its psychology as well. The inevitable decline of old age engenders strong feelings of inferiority and inadequacy. Growing incapacity makes the older person more dependent, restricts his social activities, and excludes him from the many competitions he once enjoyed. Isolation and loneliness become more pronounced as friends in his own age group begin to die out. Feeling insecure and displaced, he gets more sensitive to imagined slights.

Younger members of the patient's family may be advised to spend a little more time visiting with him and letting him talk about the past. They can be urged to consult him more frequently, giving him back the prestige of belonging. They can encourage him by telling him that he is looking well, and by thinking up cheerful things to buoy up his spirits. If some of his ways seem to them outmoded and ritualistic, they can be reminded that the old, familiar ways are important in promoting his feeling of security. Above all, if those closest to him can give him enough attention and affection to satisfy his emotional needs, he will not have to resort to antisocial behavior to satisfy them. With an improved understanding of emotional motivations, members of the family can cooperate with the physician in helping the patient achieve a better adjustment.

The patient himself can probably gain considerable reassurance by talking with his physician. The knowledge that a busy professional man is nevertheless interested in his difficulties will help him to regain self-confidence. The authority and influence of the physician can do much to reduce his anxieties and bolster his self-esteem. This can be effective therapy. Indeed, one authority has written that no other psychiatric situation responds so well to suggestion as does the problem of senility, when handled with kindness and humor, gentleness and deference. With the understanding help of their physicians, thousands of elderly people are living out their lives cheerfully and usefully. As the population of older persons grows, the physician's help is needed more and more in their search for a happier adjustment.

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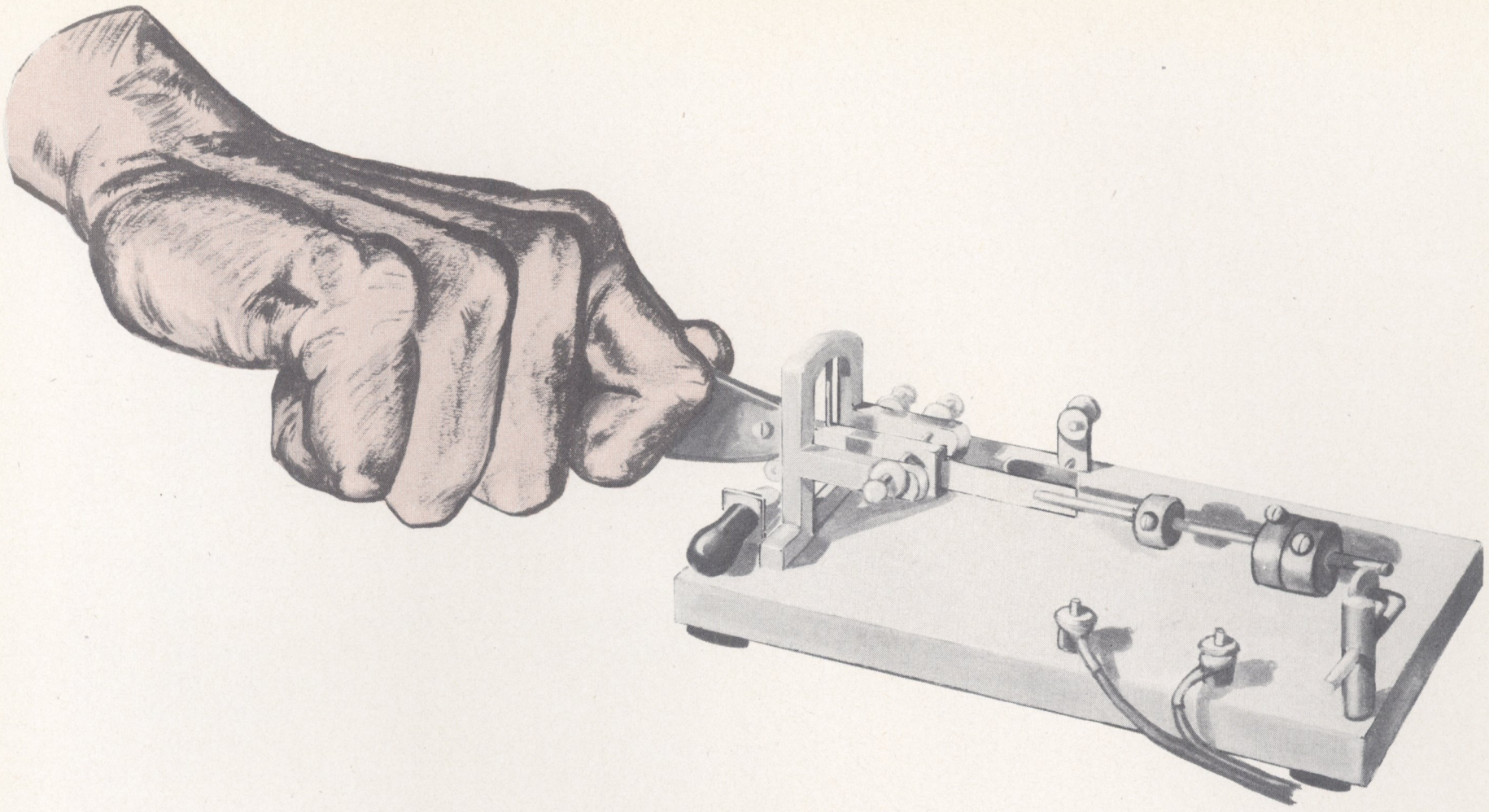

PSYCHOSOMATIC ASPECTS OF CONVALESCENCE: In convalescence, when the patient is no longer challenging diagnostically or therapeutically, the physician's interest tends to shift to new and yet unsolved problems. The visits are shorter, the examinations less searching. The patient who is recovering normally will enjoy this freedom from medical inquisitiveness. As healing proceeds, he gradually takes up his former interests. At this stage, the devotion and consideration of the family can do much to restore his self-confidence.

Those in whom illness activates unconscious fears, resentment, or other disturbing emotions, may present a different pattern of convalescence. The physician's casual manner may then be regarded as rejection, and the solicitous atmosphere of the hospital which caters to the patient's needs is in sharp contrast to the competitive world outside. When the patient feels inadequate to cope with the burdens and responsibilities that illness excused him from, his symptoms are apt to be perpetuated.

In chronic illness, the emotional disability may bear little relation to the extent of pathological involvement. The patient may be greatly benefited if he can come to distinguish between his personality problems and his disease. Rapid improvement may result if through patient counselling by a friendly and understanding physician, he can be brought to recognize the influence which his emotions are having on his physical symptoms.

Bernstein, S.: Psychosomatic Aspects of Convalescence, J. Mt. Sinai Hosp. 18:1 (May-June) 1951.

A MODERN CONCEPT OF BREAST FEEDING: Pediatricians are generally of the opinion that, whenever feasible, breast feeding is best for the infant, both physically and emotionally. When breast feeding is not possible, however, artificial formulas are now available which are almost identical to breast milk. Therefore, the main difference between artificial and breast feeding lies in the warm emotional relationship between mother and child during nursing.

There are some mothers who are physically capable of nursing their infants, but who are psychologically unsuited for the role. They give varied reasons for not wanting to nurse their children. Some express dread of discomfort, abscess, ruining of their figure, or of being "tied down." The physician can learn the degree of reaction against nursing and make an effort to remove any misconceptions about it. The mother herself will make the final decision. She may be told that if she chooses to nurse, it can be discontinued if the experience is not happy and successful. If the woman's objections to nursing cannot be eradicated, it is questionable whether her child would derive adequate emotional satisfaction from being nursed by her, because her feelings of resentment would be apparent to the child in her unsympathetic handling of the nursing situation. Under these conditions breast feeding would defeat its own purpose, by denying the child the emotional reassurance needed at this time. It would be far better for the child to be held gently in caressing arms and given a bottle by a happy and undisturbed mother. In this way antagonism detrimental to the mother-child relationship can be avoided in those cases where anxiety over nursing cannot be dispelled from the woman's mind.

Women unable to nurse their babies because they have to work should have the reassurance that their children will not suffer from being bottle-fed. This will protect the mother from feeling remorse over a situation she cannot control.

The women who are anxious to nurse their babies, and those who have no deep feelings pro or con, will nearly always be capable of it, and these should be encouraged to nurse them for a little while at least.

QUICKIES

In all cases, the nursing situation, whether at breast or bottle, should be emotionally satisfying to both the mother and the child. The physician can do his part to assure this if he tempers his advice to the mother with his knowledge of her emotional attitudes to breast feeding.

Levine, M.: A Modern Concept of Breast Feeding, J. Ped. 38:4 (Apr.) 1951.

THE AFFECTIVE RESPONSE OF AN ULCERATIVE COLITIS PATIENT TO CORTISONE: A case is described of a thirty-five year old housewife who presented the typical laboratory and physical findings of ulcerative colitis. In addition, she was evasive, apathetic, and extremely uncommunicative. She failed to improve on the usual regime of antibiotics and supportive therapy. Finally, cortisone was given for a period of 15 days. There was a dramatic change in her emotional outlook within 48 hours, although it was several days before any change was noted in her physical condition. She became animated and talkative, friendly and cooperative. She related for the first time the feelings of rivalry with her sister with whom she had quarreled shortly before the onset of her bloody diarrhea. She was able to link past episodes of this with other emotional trauma. The physical improvement came about after a week of cortisone treatment, and the patient remained alert and emotionally responsive throughout.

McKell, T. et al: The Affective Response of a Patient with Ulcerative Colitis to Cortisone, Gastroenterol. 17:1 (Jan.) 1951.

PATHOLOGICAL BOREDOM AND INERTIA: Every physician sees patients who, despite serious disabilities, have an enormous zest for life. He also sees those with little or no physical disturbance, who act as though they had nothing whatever to live for. The latter attitude of mind is examined in an article which terms this condition "pathological boredom". The author states that excessive boredom is a manifestation of inhibition in some important area of life. When carried to an extreme, this is recognized clinically as depression. The patient's capacity for almost all types of action is retarded, and some types become utterly impossible to him. A person with this pattern of thinking will respond with dread to the prospect of whatever activity represents his particular aversion. Some patients are inhibited with regard to the prospect of pleasure, and tend to withdraw from scenes of gaiety. Such a patient may overwork compulsively, without realizing that he is just doing it to avoid having to indulge in play. A basis for subconscious reactions of this nature may be found in an early history of Puritanical training which left the impression that pleasure itself was sinful and laughter bore the stigma of selfishness.

The opposite inhibition is more frequently encountered. A good many people seem to be "allergic to work", their boredom with gainful occupation often being so severe as to compel them to change jobs frequently. Work inhibition appears to stem from problems of competition arising in early life. In cases where sibling rivalry was unusually severe, or when a child was forced to compete with a domineering, overweening father, the tendency might easily be developed to withdraw from all competitive pursuits. Also, the fear of making mistakes, fostered by perfectionist parents, may result in functioning below capacity on a job.

The simplest therapy suggested for the patient with pathological boredom is to advise him to take up some new and interesting hobby, to make new contacts, to try to find a means for creative expression. The only difficulty is that if he is seriously inhibited, his inertia will not permit him to maintain an interest in these things, either. Then, psychotherapy oriented toward finding the underlying cause of the inhibition is indicated and may be the means of eventually overcoming the patient's habitual boredom.

Bieber, I.: Pathological Boredom and Inertia, Am. J. Psychotherapy, 5:215, (Apr.) 1951.

Continued from page 76

is not hostile at all. Actually he is rather nice, even willing to allow the patient minor outbursts of temper and aggression without the censorship the patient has always expected and frequently received from others in the past. By his attitudes and actions in the interview situation the physician exemplifies the kind of person the patient has been looking for all his life but never found—a kind, dependable, understanding person who gives the patient the feeling that he will always be there in time of need. These special emotional needs have never been satisfied in the life of the anxious patient. By satisfying them the physician corrects a serious psychological deficiency in the patient's personality.

Several Interviews Are Usually Necessary

A cure is seldom achieved in one or two office visits—especially with patients who are chronically anxious. At times the physician may need to encourage the patient to talk about himself. Leading questions about the patient's job, homelife, school experiences, if tactfully put, will usually start the patient talking. Often anxious patients are so glad to find someone who is interested in their story that they do not need such encouraging. After a few interviews the reasons for the patient's anxiety will often become apparent. Perhaps he was adopted by foster parents who took on a child because they felt their marriage had been barren and a "child" would "perhaps make them love each other again." As the story unfolds it is revealed that the foster parents had great ambitions for their adopted child—ambitions the boy could never hope to reach with the meager intellectual assets he had—ambitions which, if achieved, were selfishly aimed at satisfying the emotional needs of the parents, regardless of the child. Not quite able to realize that he was intellectually inadequate, the patient unknowingly developed neurotic anxiety from his frustrations. Thus unconsciously he "saved face." He could blame his illness (without realizing it, of course) for his inability to achieve, at the same time gaining sympathy instead of blame from his parents. Some of these relationships between the patient's illness and his early emotional experiences will become apparent to the patient spontaneously. Others will have to be pointed out. Still others are better left undetected or uninterpreted.

The Patient Should Pace the Interview

An interview proceeding at an emotional pace dictated by the patient's ability to understand and assimilate will make psychotherapeutic progress. It is a new life for the patient in which he has, perhaps for the first time since he was born, experienced a feeling of self worth. The unconscious emotional logic of such psychotherapy goes something like "The doctor thinks I'm O.K., so there must be others who will think the same thing, others who will accept me, dumb as I am, at face value. I don't have to be ill to gain acceptance or avoid facing my inadequacies. I may be dumber, but I'm just as good as the next person." This is the emotional bridge that spans the torrent of anxiety which has been erosively wearing away the substance of the patient's personality. It is "the way back" to normal social living, to the spontaneous give-and-take of an everyday association with people. Once the patient sees the motivations at work in his emotional life and regains through the physician confidence in himself and other people, his symptoms will often disappear, because there will be less reason for them to continue. The patient will no longer be as intensely threatened by other people or his own impulses as he had been. If he is no longer so severely threatened, whatever physiological mobilization (symptom-formation) has been required in the past to meet such pressing threats will probably no longer be necessary. However, the patient is not freed from threat. But the threats of living will have become clothed in their proper vestments, their objectively real characteristics. They are stripped of their exaggerated emotional meaning. After such psychotherapy the patient more frequently sees whatever threat there is in his life as it really is and realistically mobilizes his defenses to meet it. This is adequate, self-preservative living.

Suggested Reading

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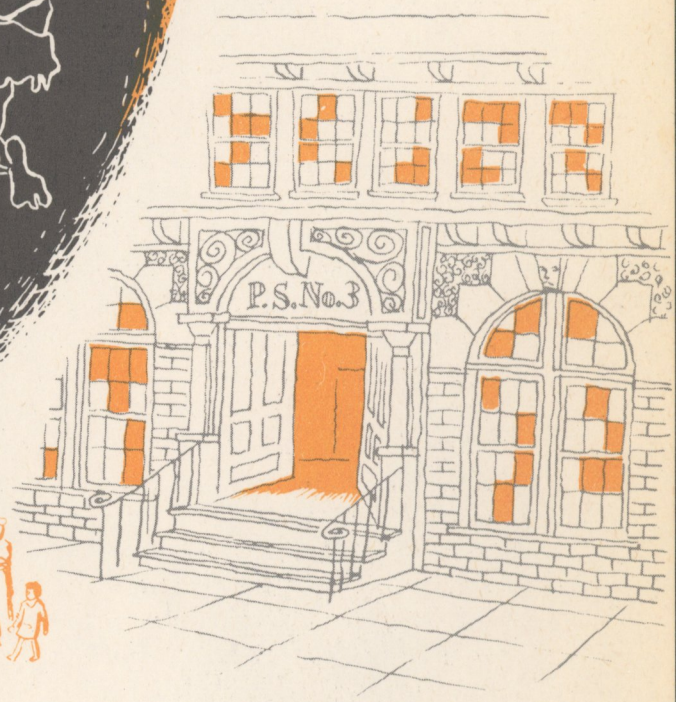

PLANNING PREVENTS PANIC

BEFORE man had knowledge of astronomy, an eclipse of the sun could produce mass hysteria. Primitive people, unprepared for the sudden darkening of their day, stampeded in terror as they tried to escape the harmless unknown. What a contrast is the picture of today's school children, prepared by repeated fire drills, who follow intelligent leadership out of harm's way when actual danger strikes. Knowledge is their power; preparedness their protection.

When a community is faced with disaster, whether fire or flood, earthquake or explosion, or some yet unfamiliar weapon of destruction, chaos may be forestalled if adequate preparation has been made in earlier, calmer times. Planning for all types of emergency must be made at the local level. The physicians of every community have an important place in that planning. They are the acknowledged leaders to whom the people turn for first aid, for accessory solace, and for continued inspiration in working out the details of rehabilitation.

Of 366 psychoneurotic cases seen in one year in a Detroit hospital, half were mild enough to respond to simple common-sense psychotherapy; 70% of these were significantly benefited by as little as four hours of treatment.